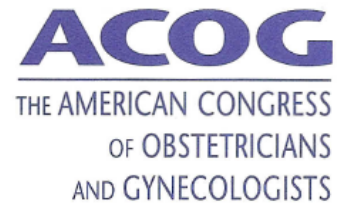


**American Congress of Obstetricians and
Gynecologists
District VIII, Hawaii (Guam & American Samoa)
Section**

Greigh Hirata, MD, FACOG, Chair
94-235 Hanawai Circle, #1B
Waipahu, Hawaii 96797



To: Senate Committee on Commerce, Consumer Protection, and
Health
Senator Rosalyn Baker, Chair
Senator Michelle Kidani, Vice Chair

DATE: Tuesday, February 9, 2016
TIME: 9:00 A.M.
PLACE: Conference Room 229

FROM: Hawaii Section, ACOG
Dr. Greigh Hirata, MD, FACOG, Chair
Dr. Jennifer Salcedo, MD, MPH, MPP, FACOG, Vice-Chair
Lauren Zirbel, Community and Government Relations

Re: SB2234 Relating to Child and Maternal Death Reviews

Position: Strongly Support

Dear Senators Baker, Kidani and Committee Members:

The American Congress of Obstetricians and Gynecologists, Hawaii Section (Hawaii ACOG) strongly supports the establishment of a Hawaii Maternal Mortality Review Panel as well as the reinstatement of Child Death Review to conduct comprehensive, multidisciplinary reviews of maternal and child deaths towards improving maternal-child health in our state. Deaths of a child or a pregnant woman are sentinel events that require proper investigations to understand the underlying causes and opportunities for prevention. The mortality reviews identify missed opportunities and remediable factors in cases of child and maternal deaths.

There currently is **no allocation of resources** to ensure the ongoing conduct of maternal and child death reviews. **Establishment of a permanently funded unit within the MCH Branch at the DOH addresses program sustainability. Many factors responsible for infant mortality are shared with maternal mortality.** These include socio-environmental factors, appropriate accessing of medical care and timely response by the healthcare system. In addition there is considerable overlap in the methodologies for determining factors contributing to

deaths and preventability. **It just makes sense to combine resources for these reviews. The Hawaii State Department of Health (DOH) is supportive of this legislation.**

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. There are approximately 10 maternal deaths annually in the state of Hawaii. Maternal mortality rates are increasing and up to 50% of all maternal deaths may be preventable. **We know that review panels work: unlike overall United States data with rising maternal death rates, the United Kingdom and the state of California have decreased their maternal mortality** by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

Hawaii, as of 2013, is one of only two states not conducting child death reviews. Previous reviews have found that up to 75% of child deaths in Hawaii were preventable. There are approximately 170 child deaths per year in the state of Hawaii. A series of recommendations from prior Child Death Reviews launched policy changes in licensed daycares and stimulated public service campaigns directed at reducing sleep related deaths. This summer's series of infant deaths, with 7 being sleep related and another 5 also preventable, highlights the importance of ongoing surveillance and active responses to minimize preventable deaths.

The appropriation for core fatality unit staffing at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews. The review panels for separate child and maternal death reviews will consist of voluntary expert members, allowing for significant in-kind support from health care providers and public health specialists.

Mahalo for the opportunity to testify, and for your support of Hawaii Women's Health.